Child Fatality Report

Report Identification Number: NY-22-092

Prepared by: New York State Office of Children & Family Services

Issue Date: Apr 18, 2023

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☐ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services had an open investigation or a CPS monitored services case.

☒ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services	DA-District Attorney	
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased

Jurisdiction: Office Of Special Investigations

Date of Death: 11/08/2022

Age: 2 year(s)

Gender: Female

Initial Date OCFS Notified: 11/15/2022

Presenting Information

A completed OCFS-7065 Agency Reporting Form was received regarding the death of the 2-year-old subject child that occurred at the time the child was in foster care. The form reflected that on 11/8/22, the foster parent administered the subject child's medication and began feeding the child through the child's gastrostomy tube. While feeding, the child's lips turned blue, and she did not have a pulse. The foster parent called 911. Resuscitative efforts in the home and in the hospital were unsuccessful and the child was pronounced deceased at 8:27PM.

Executive Summary

This fatality report concerns the death of the 2-year-old subject child that occurred on 11/8/22. At the time of the subject child's death, she was in the custody of the Commissioner of the Administration for Children's Services (ACS) with a permanency planning goal of Return to Parent. The child had been in foster care since 1/27/22, due to the parents' failure to provide adequate supervision and medical care.

On 11/9/22, ACS was notified of the subject child's death. ACS learned that the child was brought by the foster parent to the emergency room on 11/7/22 to have her gastrostomy tube replaced. The child was discharged from the hospital following the procedure. The next evening, on 11/8/22, around 7:15PM, the foster parent was preparing to feed the child and administer her medication. The child was reliant on the gastrostomy tube for feeding and receiving medication. At 7:33PM, the foster parent called 911 as the child appeared to be in distress. Her eyes rolled back in her head, her head fell to the side, and she was spitting. CPR was initiated in the foster home and the child and foster parent were transported to the hospital via ambulance. The child arrived at the hospital in cardiac arrest and resuscitative efforts proved unsuccessful. The child was pronounced deceased at 8:27PM.

The medical examiner performed an autopsy. The child died due to peritonitis caused by the child's gastrostomy tube being misplaced in her abdominal cavity. Law enforcement investigated and closed their case as criminality was not suspected.

ACS completed a visit to the foster home and the foster parent's mother's home where the fatal incident occurred. ACS interviewed the foster parent and her mother, contacted the treating hospital, reviewed pertinent case records, and communicated with the foster care agency who had case planning responsibility. The foster parent's own children were assessed to be safe in her home. There were no other siblings to the subject child.

The parents were offered burial assistance, which they declined. They were provided with information on bereavement services; however, it was unknown if they utilized the resources offered.

PIP Requirement

OCFS' review resulted in citations. In response, ACS and the cited agency will submit a Program Improvement Plan (PIP) to the New York City Regional Office within 45 days of the receipt of this report which will identify what action(s) the respective agencies have taken, or will take, to address the cited issues.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** N/A

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** N/A
- **Was the determination made by the district to unfound or indicate appropriate?** N/A

Explain:
This was not an SCR reported fatality, therefore a determination and safety assessments were not required.

Was the decision to close the case appropriate? N/A

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
ACS gathered information regarding the fatality and determined there was no reason to suspect the death was the result of abuse or maltreatment. The CPS services case remained open at the time this fatality report was written.

Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? ☐ Yes ☒ No

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 11/08/2022 **Time of Death:** 08:27 PM

Time of fatal incident, if different than time of death: 07:33 PM

County where fatality incident occurred: Bronx

Was 911 or local emergency number called? Yes

Time of Call: Unknown

Did EMS respond to the scene? Yes

At time of incident leading to death, had child used and/or ingested alcohol or drugs? N/A

Child's activity at time of incident:

☐ Sleeping ☐ Working ☐ Driving / Vehicle occupant
☐ Playing ☒ Eating ☐ Unknown

☐ Other

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	2 Year(s)
Deceased Child's Household	Foster Parent	No Role	Female	33 Year(s)
Deceased Child's Household	Other Child - Foster Parent's Child	No Role	Female	14 Year(s)
Deceased Child's Household	Other Child - Foster Parent's Child	No Role	Male	12 Year(s)
Deceased Child's Household	Other Child - Foster Parent's Child	No Role	Male	9 Year(s)
Deceased Child's Household	Other Child - Foster Parent's Nephew	No Role	Male	13 Year(s)
Other Household 1	Father	No Role	Male	34 Year(s)
Other Household 1	Mother	No Role	Female	21 Year(s)

LDSS Response

ACS was notified of the subject child's death and immediately began gathering information regarding the circumstances surrounding the death. ACS spoke with hospital staff and learned that the foster parent had brought the subject child to the same emergency room the day prior to the fatality because the child's gastrostomy tube required replacement. The hospital staff did not express any concerns regarding the subject child or the foster parent's care of the child. The child's gastrostomy tube was replaced, and the child was released. On the day of the fatality, the subject child arrived at the hospital in cardiac arrest at 7:49PM. Resuscitative were initiated in the foster home. EMS took over upon their arrival, and efforts were continued at the hospital for almost an hour; however, were unsuccessful and the child was pronounced deceased at 8:27PM.

ACS interviewed the adults present during the fatal incident regarding the events leading up to the child's death. The foster mother was a kinship foster parent and the subject child was placed in her home on 10/19/22, following a lengthy hospital stay due to her medical conditions. The foster mother received special medical training to meet the child's medical needs. The subject child had a history of seizures which were controlled through medication. The foster parent provided all the child's medications and food through her gastrostomy tube. On 11/7/22, the child's gastrostomy tube dislodged, and the foster mother brought the child to the hospital to have it replaced. The foster mother noticed that she thought the replacement tube was a different size. The following day, 11/8/22, the child's visiting nurse saw the child and reported no concerns for her condition at that time, nor did the foster parent express any concerns to the nurse. Around 7:15PM that evening, the child was in her stroller and the foster parent was preparing to administer the child's medication and food. The foster parent explained that suddenly the child rolled her eyes, her head fell, and she started spitting. This occurred around 7:33PM and the foster parent called 911. The foster parent's sister, who was CPR certified, initiated CPR. The foster parent rode in the ambulance with the child. The fatal incident occurred in the foster parent's mother's home. ACS interviewed the foster parent's mother, who reported no concerns for the foster parent's ability to care for the child. The foster parent notified the child's parents and the foster care agency of the child's death.

ACS reviewed the open foster care services case documentation and reached out to the foster care agency. The subject

child was placed in the kinship foster home on 10/19/22. The agency had certified the home and expressed no concerns regarding the foster parent; however, had not yet completed a foster home visit since the child's placement into the home. The parents had twice weekly, supervised visits with the subject child. The foster care agency was in regular communication with the child's parents and had offered burial assistance and bereavement services in response to the fatality.

ACS spoke with the medical examiner, who reported the child died from therapeutic complications. The child presented with peritonitis caused by the child's gastrostomy tube being misplaced in her abdominal cavity, which was done by the treating hospital. There were no signs of abuse or maltreatment observed. Law enforcement investigated and the case was closed with no arrests.

The subject child was the only child receiving services on the case, and the only child to the parents. The investigation into the death of the child was closed; however, the CPS services case with the parents remained open at the time this report was written. The pending Article 10 Neglect Petition against the parents on behalf of the child was withdrawn.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From a medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality referred to an OCFS approved Child Fatality Review Team? No
Comments: The New York City area does not have an OCFS approved Child Fatality Review Team.

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☐	☐	☒	☐
All appropriate Collaterals contacted?	☐	☒	☐	☐
First Responders	☐	☒	☐	☐
Pediatrician	☐	☒	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:
The record did not reflect ACS spoke with emergency medical services or obtained 911 records. The pediatrician was not contacted; however, medical appointments were reviewed in the most recent FASP.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☐	☒	☐	☐	☐	☐
Economic support	☐	☒	☐	☐	☐	☐	☐
Funeral arrangements	☐	☒	☐	☐	☐	☐	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☒	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☒	☐	☐	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☒	☐	☐	☐	☐	☐	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? Yes
Explain:

The parents were provided with bereavement counseling services; however, it was unknown if they engaged in any counseling services.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was the child ever placed outside of the home prior to the death?	Yes
Were there any siblings ever placed outside of the home prior to this child's death?	No
Was the child acutely ill during the two weeks before death?	No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
01/12/2022	Deceased Child, Female, 1 Years	Father, Male, 34 Years	Inadequate Guardianship	Substantiated	No
	Deceased Child, Female, 1 Years	Father, Male, 34 Years	Lack of Medical Care	Substantiated	
	Deceased Child, Female, 1 Years	Mother, Female, 20 Years	Inadequate Guardianship	Substantiated	
	Deceased Child, Female, 1 Years	Mother, Female, 20 Years	Lack of Medical Care	Substantiated	

Report Summary:
Multiple reports were received which alleged the subject child was born with pre-existing medical conditions and required a higher level of care and treatment. The parents were aware of the need to bring the child to medical appointments. Despite this knowledge, the parents continued to fail to bring the child to follow-up appointments, evaluations, and weight checks, which resulted in the child's heath deteriorating. The child's health had deteriorated to the point the child was unable to hold down food and was vomiting blood.

Report Determination: Indicated | **Date of Determination:** 03/02/2022

Basis for Determination:
ACS substantiated the allegations against the parents. ACS determined that the parents failed to ensure the child was being fed properly. The parents did not follow medical recommendations on feeding and as a result, the child lost weight. The parents were aware of the child's medical history and medical diagnoses. The parents did not comply with medical appointments vital to the child's well-being. The child's health declined as a result, and she was hospitalized. The report was indicated, the child was remanded to ACS and placed in foster care, and the case remained open for ongoing services.

OCFS Review Results:
ACS initiated their investigation within 24 hours, contacted the sources of the multiple reports, and reviewed case history. The family was known to ACS at the time as they were receiving PPRS services. A conference was held with the family and relevant collaterals and family court was accessed as a result. An Article 10 Neglect Petition was filed on 1/27/22 and a removal was granted with ACS supervised visitation. The child was discharged from the hospital on 2/2/22 to kinship foster care where she remained at the time the CPS investigation was closed. PPRS remained open with the

family for ongoing monitoring.

Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/29/2021	Other Child - Maternal Uncle, Male, 17 Years	Grandparent, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - Maternal Uncle, Male, 17 Years	Grandparent, Female, 39 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - Maternal Uncle, Male, 11 Years	Mother, Female, 20 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Other Child - Maternal Uncle, Male, 11 Years	Mother, Female, 20 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Maternal Uncle, Male, 11 Years	Mother, Female, 20 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Other Child - Maternal Uncle, Male, 11 Years	Grandparent, Female, 39 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Other Child - Maternal Uncle, Male, 11 Years	Grandparent, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Maternal Uncle, Male, 11 Years	Grandparent, Female, 39 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 1 Years	Mother, Female, 20 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 1 Years	Mother, Female, 20 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 1 Years	Grandparent, Female, 39 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 1 Years	Grandparent, Female, 39 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 1 Years	Mother, Female, 20 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
The report alleged that the mother failed to properly feed and administer the subject child's seizure medication. As a result, the child was at risk of seizure activity. The report alleged the mother was using marijuana to the point of impairment while caring for the subject child and the mother's 11-year-old brother. The maternal grandmother was aware and continued to allow the mother to care for the minor children. The maternal grandmother was using alcohol to the point of impairment while caring for the subject child and her own 11-year-old son. While under the influence of alcohol, the maternal grandmother hit the 11-year-old with a stick and exposed the 11-year-old to drugs.

Report Determination: Unfounded | **Date of Determination:** 12/28/2021

Basis for Determination:
ACS determined there was no credible evidence to support the allegation of IF/C/S as adequate food was observed throughout the CPS investigation. PD/AM was unsubstantiated as the children did not appear to be impacted by the adults' marijuana use, and use did not occur in the presence of the children. ACS determined there was no credible evidence to support the allegation of IG as the children did not exhibit behavior that suggested they were "not guided by" the adults, which did not address the allegation. The LMC narrative referred to the wrong subject.

OCFS Review Results:
ACS initiated their investigation within 24 hours and contacted the source of the report. The family was known to ACS. Despite allegations concerning the subject child's medical care, medical providers were not contacted until two months after the report was initiated and confirmation was not received from all medical providers. The case was closed prior to PPRS workers being successfully contacted. The record did not reflect follow-up to the requested drug screen and evaluation for the maternal grandmother or mother prior to the case being closed. There were additional missing collateral contacts, and the Investigation Conclusion Narrative did not address all allegations adequately.

Are there Required Actions related to the compliance issue(s)? ☒Yes ☐No

Issue:
Contact/Information From Reporting/Collateral Source
Summary:
There were missed opportunities to gather collateral information, such as follow-up on requested substance use evaluations and drug screens, as well as information from the maternal grandmother's medical marijuana prescriber and the PPRS caseworker.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(b)
Action:
ACS will make diligent efforts to contact collaterals to attempt to gather relevant information as it pertains to safety, risk, and a determination of the allegations.
PIP Requirement:
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

Issue:
Failure to provide notice of report
Summary:
The subject child's father was not provided a notification letter or added to the report.
Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)
Action:
ACS will mail or deliver notification letters to subject(s), parent(s) and other adults named in the report within the first seven days following the receipt of the report.
PIP Requirement:
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/31/2021	Other Child - Maternal Uncle, Male, 17 Years	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated	Yes
	Other Child - Maternal Uncle, Male, 17 Years	Father, Male, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Other Child - Maternal Uncle, Male, 17 Years	Grandparent, Female, 38 Years	Inadequate Guardianship	Unsubstantiated	

Other Child - Maternal Uncle, Male, 17 Years	Grandparent, Female, 59 Years	Inadequate Guardianship	Unsubstantiated
Other Child - Maternal Uncle, Male, 17 Years	Other - Step Grandfather, Male, 43 Years	Inadequate Guardianship	Unsubstantiated
Other Child - Maternal Uncle, Male, 11 Years	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated
Other Child - Maternal Uncle, Male, 11 Years	Father, Male, 33 Years	Inadequate Guardianship	Unsubstantiated
Other Child - Maternal Uncle, Male, 11 Years	Grandparent, Female, 38 Years	Inadequate Guardianship	Unsubstantiated
Other Child - Maternal Uncle, Male, 11 Years	Grandparent, Female, 59 Years	Inadequate Guardianship	Unsubstantiated
Other Child - Maternal Aunt, Female, 15 Years	Other - Step Grandfather, Male, 43 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 10 Months	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 10 Months	Father, Male, 33 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 10 Months	Grandparent, Female, 38 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 10 Months	Grandparent, Female, 59 Years	Inadequate Guardianship	Unsubstantiated
Deceased Child, Female, 10 Months	Mother, Female, 19 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - Maternal Uncle, Male, 11 Years	Mother, Female, 19 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Female, 10 Months	Father, Male, 33 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - Maternal Uncle, Male, 11 Years	Father, Male, 33 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Female, 10 Months	Grandparent, Female, 38 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - Maternal Uncle, Male, 11 Years	Grandparent, Female, 38 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Deceased Child, Female, 10 Months	Grandparent, Female, 59 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - Maternal Uncle, Male, 11 Years	Grandparent, Female, 59 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated
Other Child - Maternal Uncle, Male, 17 Years	Grandparent, Female, 38 Years	Parents Drug / Alcohol Misuse	Substantiated
Other Child - Maternal Uncle, Male, 11 Years	Grandparent, Female, 38 Years	Parents Drug / Alcohol Misuse	Substantiated
Other Child - Maternal Uncle, Male, 17 Years	Grandparent, Female, 59 Years	Parents Drug / Alcohol Misuse	Unsubstantiated
Other Child - Maternal Uncle, Male, 11 Years	Grandparent, Female, 59 Years	Parents Drug / Alcohol Misuse	Unsubstantiated

Report Summary:
It was alleged the maternal grandmother, and maternal great-grandmother sold crack cocaine from the home, in the presence of the maternal grandmother's children and the subject child. The subject child's parents were aware but failed to address the situation. On an ongoing basis, the maternal grandmother and great-grandmother used crack cocaine while in a caretaking role. All adults in the home failed to provide the children with adequate food, to the point the children missed meals and were alleged to be hungry, and the subject child was alleged to be underweight.

Report Determination: Indicated | **Date of Determination:** 09/29/2021

Basis for Determination:
ACS substantiated the allegations of PD/AM against the maternal grandmother regarding her children. ACS determined there was some credible evidence to support the allegation as mandated reporters smelled alcohol on the maternal grandmother's breath during a visit in which her two children were present. Additionally, the maternal grandmother was arrested for substance possession. The allegation of PD/AM was unsubstantiated against the great-grandmother as she did not reside with the family and ACS found no evidence to support the allegation. Allegations of IG were unsubstantiated and allegations of IF/C/S were unsubstantiated as adequate food was observed throughout the CPS investigation.

OCFS Review Results:
ACS initiated their investigation within 24 hours, interviewed the family members regarding the allegations, contacted collaterals, and completed a CPS history check on the family. The Investigation Conclusion Narrative as it pertained to the allegation of Inadequate Guardianship was contradictory, as it stated no credible evidence was revealed, yet noted the children were not properly cared for. Additionally, the Narrative did not appropriately address the allegation of Inadequate Guardianship for all children. The case was indicated and opened for ongoing services. The subject child and her parents were not a part of the open case as they resided in a separate household.

Are there Required Actions related to the compliance issue(s)? ☒Yes ☐No

Issue:
Case record contains information that is relevant, useful, factual and objective

Summary:
The mother to the subject child was listed on the CPS investigation and her name, date of birth, and PID were not correct.

Legal Reference:
18 NYCRR 428.1(a) and 18 NYCRR 428.1(b)(1)

Action:
ACS records must contain information that is relevant, useful, factual, and objective to best reflect accuracy throughout documentation. Such information is pertinent to investigations and the review of service needs.

PIP Requirement:
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
07/31/2021	Deceased Child, Female, 10 Months	Mother, Female, 19 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	Yes
	Deceased Child, Female, 10 Months	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 10 Months	Father, Male, 33 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Female, 10 Months	Father, Male, 33 Years	Inadequate Guardianship	Unsubstantiated	

Report Summary:
ACS received a report which alleged the mother and father were aware that other family members were using and selling illegal substances in the presence of the subject child. The parents failed to address the situation. Additionally, the mother and father failed to provide the subject child with adequate food and the child was missing meals for whole days. As a result, the subject child was alleged to be hungry and underweight.

Report Determination: Unfounded	**Date of Determination:** 08/26/2021

Basis for Determination:
ACS unsubstantiated the allegations against the parents regarding the subject child. ACS observed the parents to meet the minimum degree of care for the subject child. ACS concluded the subject child was brought to all medical appointments. ACS observed adequate food, clothing, and sleeping arrangements for the child and ACS determined the child was receiving prescribed medication for her chronic medical conditions.

OCFS Review Results:
This investigation was conducted simultaneously to the above listed 7/31/21 investigation. ACS created a separate case for the mother, father, and child to more accurately reflect the two separate households. Despite being investigated simultaneously, the investigation must stand on its own. The investigation was not initiated timely, the 7-day Safety Assessment was completed two weeks late on 8/20/21, all reported allegations were not addressed, and proper provisions for the subject child were not documented to have been observed until 8/23/21, despite concerns being alleged on 7/31/21. The CPS investigation was closed, and the family remained open with PPRS for ongoing services.

Are there Required Actions related to the compliance issue(s)? ☒Yes ☐No

Issue:
Review of CPS History

Summary:
There was no documentation of a CPS history check for the parents.

Legal Reference:
18 NYCRR 432.2(b)(3)(i)

Action:
Within 1 business day of a report, ACS must review all SCR records of prior reports, including legally sealed reports, and document such. Within 5 business days, ACS will review its own CPS record(s) that apply to the prior reports, including legally sealed unfounded and family assessment response reports.

PIP Requirement:
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

Issue:
Timely/Adequate Seven Day Assessment

Summary:
The 7-Day Safety Assessment was not completed on time.

Legal Reference:
SSL 424(3);18 NYCRR432.2(b)(3)(ii)(c)

Action:
ACS will document and approve all Safety Assessments within the required timeframes.

PIP Requirement:
ACS will submit a PIP to the New York City Regional Office within 45 days of the receipt of this report. The PIP will identify action(s) the ACS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, ACS will review the plan and revise as needed to address ongoing concerns.

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
06/29/2021	Deceased Child, Female, 9 Months	Father, Male, 33 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	No
	Deceased Child, Female, 9 Months	Father, Male, 33 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 9 Months	Father, Male, 33 Years	Malnutrition / Failure to Thrive	Unsubstantiated	
	Deceased Child, Female, 9 Months	Father, Male, 33 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 9 Months	Mother, Female, 19 Years	Inadequate Food / Clothing / Shelter	Unsubstantiated	
	Deceased Child, Female, 9 Months	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated	
	Deceased Child, Female, 9 Months	Mother, Female, 19 Years	Malnutrition / Failure to Thrive	Unsubstantiated	
	Deceased Child, Female, 9 Months	Mother, Female, 19 Years	Parents Drug / Alcohol Misuse	Unsubstantiated	
	Deceased Child, Female, 9 Months	Mother, Female, 19 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
ACS received an SCR report on 6/29/21, which alleged the mother and father had a history of substance misuse. On a regular basis, the parents used cocaine, marijuana, and alcohol to excess while the subject child was in their care. The parents could not care for themselves or the subject child and had few provisions for the child. The parents sold the child's formula and as a result, the child went without food and lost weight. The child was developmentally behind, the parents did not have a stable residence, and they fought in the presence of the child.

Report Determination: Unfounded | **Date of Determination:** 08/26/2021

Basis for Determination:
ACS observed the parents to have met the minimum degree of care for the child. The child had been brought to medical appointments. Adequate food, clothing, and sleeping arrangements were observed. The parents were providing the child with prescribed medication for her chronic medical conditions. ACS did not observe the parents to be under the influence of any substances and did not observe drug paraphernalia in the home. Although the family resided in a shelter, the child had appropriate provisions. ACS learned the child was diagnosed Failure to Thrive; however, collaterals stated that was likely due to a genetic disorder and not caused by the parents.

OCFS Review Results:
ACS initiated their investigation within 24 hours, conducted multiple home visits with the family, and maintained appropriate collateral contacts. The family was appropriately offered and accepted PPRS. The allegations were unsubstantiated, and a family services stage was opened for ongoing services and monitoring. Appropriate referrals were made to assist the family in meeting the subject child's needs and ACS provided a Pack 'N Play to the family.

Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
10/14/2020	Deceased Child, Female, 22 Days	Mother, Female, 19 Years	Inadequate Guardianship	Unsubstantiated	No

Deceased Child, Female, 22 Days	Father, Male, 32 Years	Inadequate Guardianship	Unsubstantiated

Report Summary:
ACS received an SCR report on 10/14/20, which alleged that the father was screaming and threatening others while swinging around the newborn subject child's car seat, with the subject child in the car seat. The father was using such force that the child was at risk of falling out of the car seat. The mother was present and did not intervene on the child's behalf. The mother and father were out of control during the incident. The subject child was not harmed. Additionally, the child was not gaining sufficient weight.

Report Determination: Unfounded **Date of Determination:** 12/11/2020

Basis for Determination:
ACS determined the parents maintained a safe home environment for the subject child. ACS observed the parents to be very careful when handling the subject child and noted the father was very protective of the child. ACS found the parents complied with the child's medical appointments, made up missed medical appointments, and the child had begun to gain weight when the CPS investigation was closed.

OCFS Review Results:
ACS initiated their investigation within 24 hours, contacted the source of the report, reviewed CPS history, and interviewed the parents regarding the allegations in the report. ACS maintained collateral contact with the child's pediatrician and learned that although the parents missed appointments, the missed appointments were made up and the child was gaining weight. ACS maintained collateral contact with the shelter system. The RAP and Safety Assessments were completed accurately. The CPS investigation was unfounded and closed. The parents were not interested in additional services.

Are there Required Actions related to the compliance issue(s)? ☐ Yes ☒ No

CPS - Investigative History More Than Three Years Prior to the Fatality

There was no CPS investigative history more than three years prior to the fatality.

Known CPS History Outside of NYS

There was no known CPS history outside of NYS.

Services Open at the Time of the Fatality

Was the deceased child(ren) involved in an open Child Protective Services case at the time of the fatality? Yes
Date the Child Protective Services case was opened: 07/28/2021

Evaluative Review of Services that were Open at the Time of the Fatality

	Yes	No	N/A	Unable to Determine
Did the service provider(s) comply with the timeliness and content requirements for progress notes?	☒	☐	☐	☐
Did the services provided meet the service needs as outlined in the case record?	☒	☐	☐	☐
Did all service providers comply with mandated reporter requirements?	☒	☐	☐	☐
Was there information in the case record that indicated the existence of behaviors or conditions that placed the children in the case in danger or increased their risk of harm?	☒	☐	☐	☐

If yes, was the response appropriate to the circumstances?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Did the service provider comply with case work contacts, including face-to-face contact as required by regulations pertaining to the program choice?	☒	☐	☐	☐
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐

Services Provided

	Yes	No	N/A	Unable to Determine
Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality?	☐	☐	☒	☐
Were services provided to parents as necessary to achieve safety, permanency, and well-being?	☒	☐	☐	☐

Family Assessment and Service Plan (FASP)

	Yes	No	N/A	Unable to Determine
Was the most recent FASP approved on time?	☒	☐	☐	☐
Was there a current Risk Assessment Profile/Risk Assessment in the most recent FASP?	☒	☐	☐	☐
Was the FASP consistent with the case circumstances?	☒	☐	☐	☐

Closing

	Yes	No	N/A	Unable to Determine
Was the decision to close the Services case appropriate?	☐	☐	☒	☐

Preventive Services History

The family accepted a preventive services referral, and a family services stage was opened on 7/28/21. Services were offered to support the first-time parents with homemaking and address the ongoing medical needs of the subject child. Service recommendations included parenting skill classes specific to caring for a medically fragile child, and mental health assessments. Both parents were referred for recommended services; however, did not engage in services. Throughout the preventive services case, it was learned that the parents continued to miss crucial medical appointments. In January 2022,

the subject child became ill and was hospitalized. Concerns were raised that the parents would be unable to comply with medical recommendations and appointments. ACS brought the case to family court and the subject child was removed from the parents' care on 1/27/22.

Foster Care at the Time of the Fatality

The deceased child(ren) were in foster care at the time of the fatality? Yes
Date deceased child(ren) was placed in care: 01/27/2022
Date of placement with most recent caregiver? 10/19/2022
How did the child(ren) enter placement? Court Order

Review of Foster Care When Child was in Foster Care at the time of the Fatality

	Yes	No	N/A	Unable to Determine
Does the case record document that sufficient steps were taken to safeguard this child's safety while in this placement?	☒	☐	☐	☐
Did the placement comply with the appropriateness of placement standards?	☒	☐	☐	☐
Was the most recent placement stable?	☒	☐	☐	☐
Did the agency comply with sibling placement standards?	☐	☐	☒	☐
Was the child AWOL at the time of death?	☐	☒	☐	☐

Visitation

	Yes	No	N/A	Unable to Determine
Was the visitation plan appropriate for the child?	☒	☐	☐	☐
Was visitation facilitated in accordance with the regulations?	☒	☐	☐	☐
Was there supervision of visits as required?	☒	☐	☐	☐

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☒	☐	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource made with required frequency?	☒	☐	☐	☐
Were face-to-face contacts with the parent/relative/discharge resource in the parent/relative/discharge resource's home made with required frequency?	☐	☒	☐	☐
Were all of the casework contact requirements for contacts with the caretakers made, including requirements for contact at the child's	☒	☐	☐	☐

placement location?				

Provider Oversight/Training

	Yes	No	N/A	Unable to Determine
Did the agency provide the foster parents with required information regarding the child's health, handicaps, and behavioral issues?	☒	☐	☐	☐
Did the provider comply with discipline standards?	☒	☐	☐	☐
Were the foster parents receiving enhanced levels of foster care payments because of child need?	☒	☐	☐	☐
If yes, was foster parent provided a training program approved by OCFS that prepared the foster parent with appropriate knowledge and skills to meet the needs of the child?	☐	☐	☐	☒
Was the certification/approval for the placement current?	☒	☐	☐	☐
Was a Criminal History check conducted? **Date:** Unknown	☒	☐	☐	☐
Was a check completed through the State Central Register? **Date:**	☐	☐	☐	☒
Was a check completed through the Staff Exclusion List? **Date:**	☐	☐	☒	☐

Additional information, if necessary:
The subject child was placed in a relative foster home at the time of her death. The home was approved for special medical needs. Criminal history and SCR clearance dates were not documented in the case record. The home closed following the child's death.

Required Action(s)

Are there Required Actions related to the compliance issues for provision of Foster Care Services?
☒Yes ☐No

Issue:	Failure to report death of child in Foster Care to RO in timely manner
Summary:	The subject child died while in foster care. The Regional Office was not notified with the required OCFS 7065 Agency Reporting Form until 11/15/22, seven days after the subject child's death.
Legal Reference:	18 NYCRR 441.7 (c)
Action:	The foster care agency will complete the OCFS 7065 form and send it to the appropriate Regional Office of the New York State Office of Children and Family Services within 72 hours of the injury, accident, or death.
Issue:	Failure to Complete a Plan Amendment
Summary:	A plan amendment was not completed following the fatality. The purpose of a plan amendment is to describe/document significant changes in the status of a case and direct a reassessment so that any necessary revisions to the service plan can be made.
Legal Reference:	18 NYCRR 428.7

Action:	The case planning agency will complete a plan amendment any time a significant change occurs in the status of the case, which includes when services end for a family member due to death. As required, this will be done within 30 days of the change if an initial FASP has already been completed, unless the change occurs within 60 days of the next FASP.
Issue:	Adequacy of case recording in FASP
Summary:	The most recent FASP did not include the father as a secondary caretaker, causing the RAP to be scored incorrectly. The father was not included as a secondary caretaker on any prior FASPs.
Legal Reference:	18 NYCRR 428.6(a)
Action:	The agency will record information gathered about family members in receipt of child welfare services, ; assist with evaluations and assessments of the family, assist with determining the family's need for services necessary to achieve the child(rens)'s permanency planning goal; assist with ascertaining family progress in meeting desired outcomes and assist with ongoing planning with the family.
Issue:	Adequacy of monitoring child/family while in foster care
Summary:	There were no documented casework contacts in the home of the parents throughout the child's foster care placement.
Legal Reference:	18 NYCRR 441.21
Action:	For children with a permanency planning goal of return to parent, casework contacts in the home of the parents are required at least once during the first 30 days of placement and at lease once every 90 days thereafter.

Foster Care Placement History

An Article 10 Neglect Petition was filed in family court on 1/27/22, and the subject child was remanded to foster care. The allegations that prompted ACS's involvement with the family at the time were Inadequate Guardianship and Lack of Medical Care. At the time of the remand, the child was admitted to the hospital for Seizure Disorder, Failure to Thrive, Severe Malnutrition, Subdural Hygromas, Acquired Positional Plagiocephaly, Lennox-Gastaut Syndrome, Hypertelorism, Chromosomal Deletion Syndrome, and Microdeletion Syndrome. Upon being medically cleared and discharged, the child was placed in a kinship foster home on 2/2/22. The child required additional medical care and was admitted to a long-term hospital facility on 4/25/22. The child received a gastrostomy tube on 8/2/22, and was again medically cleared and discharged to a new kinship foster home on 10/19/22. The parents were offered twice weekly supervised visits throughout the child's foster care placement. The parents required frequent redirection and casework counseling at visitation. The permanency planning goal was "return to parent"; however, the parents made limited progress on their service plan goals. The child died while in foster care. There was no fact finding as the petitions were withdrawn upon the child's death.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation?

☒ Family Court ☐ Criminal Court ☐ Order of Protection

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
01/27/2021	There was not a fact finding	Article 10 Remand

Respondent:	062524 Father Male 34 Year(s)
Comments:	Article 10 Neglect Petitions were filed against the parents on 1/27/22, and ACS requested the remand of the subject child. The Judge approved the remand and the subject child was placed in foster care with a relative. Due to the subject child's death on 11/8/22, the petitions were withdrawn on 11/17/22 prior to a fact finding being held.

Family Court Petition Type: FCA Article 10 - CPS		
Date Filed:	**Fact Finding Description:**	**Disposition Description:**
01/27/2021	There was not a fact finding	Article 10 Remand
Respondent:	062523 Mother Female 21 Year(s)	
Comments:	Article 10 Neglect Petitions were filed against the parents on 1/27/22, and ACS requested the remand of the subject child. The Judge approved the remand and the subject child was placed in foster care with a relative. Due to the subject child's death on 11/8/22, the petitions were withdrawn on 11/17/22 prior to a fact finding being held.	

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No